

SDI Online Tutorial: Physician/Practitioner Representative Certification



State of California

Employment Development Department

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Home

Unemployment

Disability

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New Online Services

Services have been enhanced and automated. You can now file a claim for Disability Insurance and Paid Family Leave online, submit forms online, and view claim information online. To register, visit:



New! SDI Online

New! SDI Online En Español

New! Troubleshooting: Accessing SDI Online

Previously registered with SDI Online?

If you have previously registered with SDI Online and want to log in to your account, visit:

SDI Online Login

SDI Online Login En Español

Disability Insurance

- How to File a DI Claim
- DI Eligibility
- DI Program Information
- DI Benefit Amounts
- New! SDI Online

More Disability Insurance Information

Paid Family Leave

- How to File a PFL Claim
- PFL Eligibility
- PFL Program Information
- PFL Benefit Amounts
- New! SDI Online

More Paid Family Leave Information

To access SDI Online accounts:

- Go to www.edd.ca.gov.
- Select **Disability**.
- Select the **SDI Online Login** hyperlink.
- Log in with the previously created Username and Password (user may be asked to answer security questions).

Language: English ▼

Contact SDI

Online

By Location

By Phone

Telephone Numbers

Automated Info System

SDI Online Login

*Indicates Required Field

*Username:

Submit

[Forgot username?](#)
[Register for a new online account](#)

SECURITY REMINDER
Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

On the **SDI Online Login** page:

- Enter your Username and select the **Submit** button to be taken to the **Home** screen.

Help | Login

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info System

Additional Authentication

*Indicates Required Field

Security Questions

To continue, please correctly answer your security questions.

Question 1: Where did you celebrate your 21st birthday?

*Answer to Question 1:

Next Cancel

If you do not recall your previous responses, please contact EDD at (800) 480-3287. The EDD staff is available from 8 a.m. to 5 p.m. (PT), Monday through Friday, except on [state holidays](#).

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In some instances, a claimant may be asked to respond to the security questions established when creating the account.

Type the answer to the security question and select **Next**.

[Help](#) | [Login](#)

Contact SDI

Online

By Location

By Phone

Telephone Numbers


Automated Info System

Confirm Your Personal Image and Log In

***Indicates Required Field**

Verify your personal image and enter your password.

Personal Image:



Personal Image Caption: Test

Username:

*Password:

(case sensitive)

Log In

[Forgot your personal image?](#)
[Incorrect personal image showing?](#)
[Forgot password?](#)

SECURITY REMINDER
Recognizing your Personal Image and Personal Image Caption helps you know that you are at a valid EDD web site, and that it is safe to enter your password.

If you do not recognize your personal image, do not enter your password.

Confirm the Personal Image and enter your Password, then select **Log In**.

Note: The Personal Image helps identify that the user has entered the correct Username on the previous screen.

Choose Physician/Practitioner

Physician/Practitioner Representative Choose Physician/Practitioner

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

Physician/Practitioner	New Action Required	Total Action Required	Saved Drafts
CATHERINE	1	3	2
RENA	4	4	0

At the **Home** page select the Physician/Practitioner link you wish to access.

A Physician/Practitioner Representative selects only one Physician/Practitioner at a time.

A Physician/Practitioner Representative may switch to a different Physician/Practitioner account by selecting **Home** from the Main Menu and selecting **Choose Physician/Practitioner**.

Home

***Indicates Required Field**

License Information

Licensee Name	License Number
John	

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number. To locate the claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.

*Search By: Patient Receipt Number
 *Patient Last Name:

Search Results

At the **Home Page** under the **Search** section the user can:

- Search by “Claim ID” to view forms to be submitted.
- Search by “My Receipt Number” to view the form submitted by the user.
- Search by “Patient Receipt Number” to submit a DE 2501 Part B Initial Claim form -
 - In order to submit the DE 2501 Part B online, the claimant must have submitted the DE 2501 Part A – Claimant Statement.
- The user will need the claimant’s submission **Receipt Number**.
- The user must also enter the claimants “Last Name” to begin their search.

A Physician/Practitioner Representative can prepare and submit any claim forms.

Home

***Indicates Required Field**

License Information	
Licensee Name	License Number
John	

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number. To locate the claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.

*Search By:

*Patient Last Name:

Search Results			
Receipt Number	Patient Name	Date of Birth	Action
R100000000033909		05-14-1981	Submit Physician/Practitioner Certificate

After the **Search Results** are populated:

- Verify the information matches the claimant's records.
- Select the **Submit Physician/Practitioner Certificate** link under the **Action** column.

If the Certificate is already submitted by another user (i.e., Physician/Practitioner Representative) the "Submit Physician/Practitioner Certificate" link will not be available.

View Claimant Portion

View Claimant DE 2501

Refer to the *Claim for Disability Insurance (DI) Benefits* (DE 2501) Claimant's Statement while completing this form. To open the Claimant's Statement, select the hyperlink below and it will open in a new window.

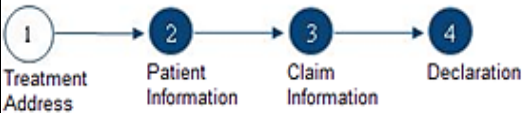
[View the Claim for Disability Insurance \(DI\) Benefits Claimant \(DE 2501\)](#)

Next **Cancel**

Users can view the claimants portion of the DE 2501 form by selecting **View the Claim for Disability (DI) Benefits Claimant** hyperlink.

Select **Next**, to begin the completion of the form.

Treatment Address



You are currently on Step 1 Treatment Address

Section 2B - Treatment Address

Select the address where the patient was treated. If the patient was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.

Address	Action
Los Angeles, CA 90066-2958 United States	Select

[Previous](#) [Not Found](#) [Cancel](#)

Verify and select the **Treatment Address** of where the patient is being treated.

Tip: If the treatment address for the patient is not displayed the user can select the **Not Found** button to add a treatment address.

Initial Questions



You are currently on Step 2 Patient Information

*Indicates Required Field

Section 1 - Patient Information

Patient's Name: Karen . Receipt Number:
Social Security Number: Date of Birth: (MMDDYYYY)
File Number:

Section 2A - Physician/Practitioner Information

Name: Ramzi Ben Youssef Treatment Address:
Los Angeles, CA 90066-2958
United States
License Number: State of Licensure: CA
Country of Licensure: United States
*Phone Number: Ext: ☐ Check here if the phone number is international
(No dashes or spaces)
Type: Physician or Surgeon (MD) Specialty (if any):

Section 3 - Treatment Information

This patient has been under my care and treatment for this medical problem:

*From: (MMDDYYYY) To: (MMDDYYYY)

*Are you presently treating the patient for this medical condition? ☐ Yes ☐ No

Treatment Intervals:

*Was the patient seen previously by another physician/practitioner or medical facility for the current disability/illness/injury?

If "Yes," enter date of first treatment: (MMDDYYYY)

*At any time during your attendance for this medical problem, has the patient been incapable of performing his/her regular or customary work? ☐ Yes ☐ No

Previous

Next

Save as Draft

Cancel

Complete the Patient Information section and select **Next**.

Mandatory fields are marked with a red asterisk.

Claim Information



You are currently on Step 3 Claim Information

*Indicates Required Field

Section 4A - Claim Information

*Date Disability Began:

Indicate if the disability was caused by accident or trauma? ☐ Yes ☐ No

For non-pregnancy related claims, you must indicate the date you released or anticipate releasing the patient.

Date you released or anticipate releasing the patient:

Check here to indicate patient's disability is permanent and total: ☐

Enter the ICD Diagnosis Code and version for the patient's primary diagnosis below:

*ICD Diagnosis Code:

ICD Diagnosis Code(s) for Secondary Disability:

ICD Diagnosis Code:

ICD Diagnosis Code:

ICD Diagnosis Code:

*Diagnosis - If no diagnosis has been determined, enter "N/A" in the space below.

Findings - State nature, severity, and extent of the disability.

Type of treatment/medication rendered to patient:

If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:

Date of entry: (MMDDYYYY) Date of discharge: (MMDDYYYY)

Patient is still hospitalized? ☐ Yes ☐ No Check here if the patient is deceased: ☐

Date of death: (MMDDYYYY) City:

Country: State:

Enter type and date of surgery/procedure most recently performed or to be performed below:

Type: Date: (MMDDYYYY)

Enter the ICD Procedure Code and version for surgery/procedure(s) planned or performed below:

ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text"/>
ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text"/>
ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text"/>
ICD Procedure Code: <input type="text"/>	Procedure Code Version: <input type="text"/>

Enter the CPT code for surgery/procedure(s) planned or performed below:

CPT Code: <input type="text"/>	CPT Code: <input type="text"/>
CPT Code: <input type="text"/>	CPT Code: <input type="text"/>

Was the patient unable to work immediately prior to the surgery or procedure? ☐ Yes ☐ No

If "Yes," please provide the first date the patient was unable to work prior to the surgery or procedure: (MMDDYYYY)

*Was this disabling condition caused and/or aggravated by the patient's regular or customary work? ☐ Yes ☐ No

*Are you completing this form for the sole purpose of referral/recommendation to an alcoholic recovery home or drug-free facility (as indicated by the patient on the DE 2501 Claim for Disability Insurance (DI) Benefits Claimant's Statement)? ☐ Yes ☐ No

Date your patient became a resident of a drug or alcohol facility (if known): (MMDDYYYY)

*Would disclosure of the information on this form to your patient be medically or psychologically detrimental? ☐ Yes ☐ No

*Is this a pregnancy related claim? ☐ Yes ☐ No

Section 5 - Pregnancy

Estimated Delivery Date: (MMDDYYYY) Pregnancy End Date (if applicable): (MMDDYYYY)

Complete applicable patient information including all mandatory fields and scroll to the bottom of the page.

If this patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for both of the following delivery types:

Vaginal delivery:	<input type="text"/>	Cesarean delivery:	<input type="text"/>
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If this patient has delivered, indicate type of delivery and any complications as applicable.

Type of delivery:

If pregnancy is/was abnormal, state the complication(s) causing maternal disability:

Complete the applicable information and select **Next**.

Additional Information

1 → 2 → 3 → 4
Treatment Patient Claim Declaration
Address Information Information

You are currently on Step 3 Claim Information

***Indicates Required Field**

Section 6 - Prognosis Information

*What complications make your patient disabled longer than normally expected?

Previous **Next** Save as Draft Cancel

Enter Prognosis
Information and select
Next.

Certification



You are currently on Step 4 Declaration

Section 7 - Certification

All Persons Authorized to Certify:

☐ All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Designated Psychologist): I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice.

☐ Nurse Practitioner: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.

☐ Registrar of a county hospital in California or medical officer of US Government medical facility: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and these conditions are shown by the patient's hospital chart.

☐ Other

Title of the person if not covered above (must be able to legally certify to a disability):

To review your information before you submit, select the hyperlink below. Your information will display below the Claimant's Statement.

[View the Claim for Disability Insurance \(DI\) Benefits Physician/Practitioner Certification \(DE 2501\)](#)

[Previous](#)

[Submit](#)

[Save as Draft](#)

[Cancel](#)

Select the appropriate box to complete certification then select **Submit** to finalize the process.

Confirmation

Confirmation

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Claim for Disability Insurance (DI) Benefits* (DE 2501). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number: [R100000000035344](#)

Once the form is submitted, the user will be taken to the **Confirmation** screen to get a Form Receipt Number.

Selecting the **Form Receipt Number** link will open up a PDF printer-friendly view of the information that is submitted.

Visit www.edd.ca.gov for more information about
State Disability Insurance.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-800-480-3287 (voice), or TTY 1-800-563-2441.